EDMUND G. BROWN JR., Attorney General
of the State of California
MARC D. GREENBAUM
Supervising Deputy Attorney General
CHRISTINA M. THOMAS, State Bar No. 171168
Deputy Attorney General
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2557
Facsimile: (213) 897-2804

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: LEILANI SUE ARNEY aka LEILANI SUE ARANDA aka LEILANI SUE DRAKE 12541 Mystic Dr. Victorville, CA 92392 Registered Nurse License No. 410602 Respondent.	Case No. 2008-340 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 19, 1987, the Board of Registered Nursing issued Registered Nurse License Number 410602 to Leilani Sue Arney aka Leilani Sue Aranda aka Leilani Sue Drake (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2008, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct . . .

. . .

(d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it."

7. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with

Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES / DANGEROUS DRUGS

9. Vicodin is a trade name for the narcotic substance hydrocodone bitartrate or dihydrocodeinone with the non-narcotic substance acetaminophen. It is classified as a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(6) and is a dangerous drug within the meaning of Business and Professions Code section 4211, subdivision (a).

10. Darvocet-N-100 is a trade name for the narcotic substance dextropropoxyphene or propoxyphene hydrochloride with the non-narcotic substance acetaminophen. It is classified as a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (c)(2) and is a dangerous drug within the meaning of Business and Professions Code section 4211, subdivision (a).

STATEMENT OF FACTS

11. From approximately January, 2003 to June 2003, Respondent worked as a Registered Nurse at St. Bernardine Medical Center located at 2101 N. Waterman Avenue, in San Bernardino, California. While working at St. Bernardine Medical Center, Respondent diverted drugs for her own use. Respondent admitted taking Viocodin from the Pyxis system for her own use and also admitted taking Vicodin from a prescription vial located in another nurse's purse. The following incidents of drug diversion were noted:

a) Patient B.C.[1/]

12. Patient B.C.'s medical records indicate that on or about February 27, 2003, a physician's order was given for Vicodin 7.5 mg ES (extra strength), "2 tablets to be taken by mouth, every 4 hours, as needed for pain." The March 4, 2003 Pyxis Report reflected that, Respondent checked out 2 Vicodin tablets at 8:11 a.m., 12:06 p.m., and 3:24 p.m., (a total of 6 tablets.)

13. The Medication Administration Record (MAR) reflects that Respondent administered Vicodin to Patient B.C. at 8:00 a.m., 12:15 p.m., and 4:00 p.m.

14. Respondent's nursing notes for Patient B.C. indicate that Respondent administered Vicodin at 8:00 a.m. and 12:00 p.m.. There is no record of Respondent's administration of the 4:00 p.m. dose of Vicodin.

b) Patient B.M.

15. Patient B.M.'s medical records indicate that on or about February 28, 2003, a physician's order was given for Vicodin 10/mg tablets, "2 tablets, as needed for pain every 4 hours."

16. The Pyxis Report for March 4, 2003 indicated that, at 8:20 a.m., Respondent signed out 2 Vicodin tablets for Patient B.M. The MAR reflects that this medication was administered at 8:30 a.m. and Respondent's nursing notes indicate that Respondent

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1. To protect the privacy of the patients, they are referred to by only the initials of their first and last name.

administered this medication to the patient at 8:00 a.m.

17. The March 4, 2003 Pyxis Report indicates that at 3:44 p.m., Respondent signed out 2 Vicodin tablets for Patient B.M. The MAR reflects that this medication was administered at 2:00 p.m. (*i.e.*, one hour and 44 minutes prior to its withdrawal from the Pyxis machine) and Respondent's nursing notes fail to reflect Respondent's administration of this medication.

18. The March 4, 2003 Pyxis Report reflects that at 6:16 p.m., Respondent withdrew 2 Vicodin tablets for Patient B.M. Both the MAR and Respondent's nursing notes for Patient B.M. fail to reflect that this medication was administered to the patient. While the physician's order requires that this medication administered "every 4 hours, as needed," the withdrawal at 6:16 p.m. was 2 hours and 32 minutes after the last administration of the medication and failed to comply with the physician's order.

19. The March 4, 2003 Pyxis Report reflects that at 6:35 p.m., Respondent removed 2 additional Vicodin tablets for Patient B.M. and wasted the tablets at 6:36 p.m.

c) Patient B.D.

20. The April 16, 2003 physician's order requires that Patient B.D. receive Vicodin ES, "one tablet, every 4 hours as needed for pain."

21. The Pyxis Report reflected that at 12:56 p.m. and 5:58 p.m., on April 16, 2003, Respondent withdrew one tablet of Vicodin for Patient B.D. (a total of two tablets.)

22. The MAR failed to reflect that Respondent administered Vicodin to Patient B.D. and failed to reflect that Respondent was assigned to care for Patient B.D. on April 16, 2003. In addition, the nursing notes failed to reflect that Respondent cared for this patient on April 16, 2003.

d) Patient S.G.

23. The April 18, 2003 physician's order requires that Patient S.G. receive Vicodin "1 to 2 tablets, every 4 hours, as needed."

24. The April 23, 2003 Pyxis Report indicated that at 1:04 p.m., Respondent signed out 2 Vicodin tablets for this patient.

25. The MAR failed to reflect that Respondent administered Vicodin and failed to reflect that Respondent was assigned to the care of Patient S.G. on April 23, 2003. Nursing notes for Patient S.G. also failed to reflect that Respondent cared for the patient on April 23, 2003.

26. Hospital records indicate that at the time Respondent withdrew these 2 Vicodin tablets, Patient S.G. was undergoing Hemodialysis.

e) Patient D.H.

27. The April 22, 2003 physician's order requires that Patient D.H. receive Vicodin "2 tablets, by mouth, every 4 to 6 hours, as needed for pain."

28. The April 23, 2003 Pyxis Report reflected that at 7:26 a.m., Respondent signed out 2 Vicodin tablets for this patient.

29. Respondent's nursing notes for Patient D.H. indicate that Respondent did not begin caring for Patient D.H., until 8:00 a.m. on April 23, 2003. The MAR does not reflect that Respondent administered Vicodin to this patient.

30. The April 23, 2003 Pyxis Report reflected that at 9:20 a.m., Respondent signed out an additional 2 Vicodin tablets for Patient D.H. This medication was signed out only 1 hour and 54 minutes after the earlier medication withdrawal. Both the MAR and the nursing notes failed to reflect that Respondent administered the medication to the patient.

31. At 1:03 p.m., on April 23, 2003, Respondent withdrew an additional 2 Vicodin tablets for Patient D.H. Neither the MAR or the nursing notes reflect that Respondent administered this medication to Patient D.H..

32. At 5:19 p.m., on April 23, 2003, Respondent withdrew an additional 2 Vicodin tablets for Patient D.H. Neither the MAR or the nursing notes reflect that Respondent administered this medication to the patient.

f) Patient B.E.

33. The April 25, 2003 physician's order requires that Patient B.E. receive Propoxyphene Napsylate 200 mg / Darvocet N 100, "2 tablets, if unable to take Tylenol #3 no more that 4000 mg a day." Patient B.E. also had an order for Acetaminophen Hydrocodone /

Vicodin 5 - 10 mg, 1 to 2 tablets (1 for mild, 2 for moderate pain), no more than 4000 mg a day.

34. The April 29, 2003 Pyxis Report reflected that at 7:32 a.m., Respondent signed out 2 Propoxyphene / Darvocet tablets for Patient B.E. The MAR failed to reflect that Respondent administered this medication.

35. The April 30, 2003 Pyxis Report reflected that Respondent signed out 2 Vicodin tablets for Patient B.E. The nursing notes fail to reflect that Respondent cared for this patient on April 30, 2003. The MAR failed to reflect that Respondent administered Vicodin to the patient.

g) Patient AR

36. The May 13, 2003 physician's order requires that Patient A.R. receive Acetaminophen-Hydrocodone 5 mg tablets, "1 to 2 tablets (1 for mild - moderate pain, 2 for moderate to severe pain), as needed." The order was discontinued at 9:00 a.m. on May 20, 2003.

37. The May 20, 2003 Pyxis Report reflected that at 7:22 a.m., Respondent signed out 2 Vicodin tablets for Patient A.R. Respondent's nursing notes for Patient A.R. did not reflect that Respondent cared for this patient on May 20, 2003. The nurse that was assigned to care for the patient on May 20, 2003, indicated, at 7:00 a.m., the patient denied any chest pain. The hospital records fail to account for administration of the Vicodin.

38. The Pyxis Report reflected that at 6:19 p.m., on May 20, 2003, Respondent signed out 2 Vicodin tablets for Patient A.R. This medication was signed out after the physician's order had been discontinued and Respondent failed to account for administration of this medication.

h) Patient D.V.

39. The May 14, 2003 physician's order requires that Patient D.V. receive Acetaminophen / Hydrocodon / Vicodin, "1 to 2 tablets for pain."

40. The May 20, 2003 Pyxis Report indicated that at 9:52 a.m., Respondent signed out 2 Vicodin tablets for this patient. The nursing notes for Patient D.V. failed to reflect that Respondent cared for this patient or that Respondent administered this medication. The MAR failed to reflect that Respondent administered this medication.

i) Patient J.J.

41. The May 20, 2003 physician's order requires that Patient J.J. receive Vicodin "1 to 2 tablets, by mouth, every 4 to 6 hours, as needed for pain."

42. The May 20, 2003 Pyxis Report indicated that at 1:51 p.m., Respondent signed out 2 Vicodin tablets for this patient. The nursing notes for Patient J.J. failed to reflect that Respondent cared for this patient. The MAR failed to reflect that Respondent administered this medication.

j) Patient C.J.

43. The May 31, 2003 physician's order requires that Patient C.J. receive Vicodin "1 to 2 tablets every 6 hours, as needed for moderate pain."

44. The May 31, 2003 Pyxis Report reflect that at 11:39 a.m., Respondent signed out 2 Vicodin tablets for Patient C.J. This Pyxis Report reflects that Respondent signed out an additional 2 Vicodin tablets for this patient, at 4:29 p.m. The second dosage of the medication was signed out within 5 hours of the first dosage and in violation of the physician's order.

45. The nursing notes failed to reflect that Respondent cared for Patient C.J. on May 31, 2003. Another nurse entered into Patient C.J.'s medical records that, at 4:00 p.m., the patient had no complaint of pain. The MAR failed to reflect that Respondent administered either the 11:39 a.m. or the 4:29 p.m. dosages of Vicodin to the patient.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

46. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (a), on the grounds of unprofessional conduct in that Respondent obtained or possessed, in violation of law, controlled substances and / or dangerous drugs. The circumstances are as follows:

a) Between February 2003 and May 2003, Respondent, on numerous occasions, and while working as a Registered Nurse at St. Bernardine Medical Center, diverted controlled substances and / or dangerous drugs, as more fully set forth in paragraphs 11 through

45, above.

b) In a signed affidavit dated August 20, 2007, Respondent admitted to diverting Vicodin for her own use and admitted taking Vicodin from another nurse's purse.

SECOND CAUSE FOR DISCIPLINE

(Use of Controlled Substance)

47. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (b), in that Respondent used controlled substances, *i.e.*, Vicodin and Darvocet, to an extent or in a manner dangerous or injurious to herself, or another person, or the public, or to the extent that such use impairs her ability to conduct with safety to the public the practice authorized by her Registered Nurse License, as more fully set forth above in paragraphs 11 through 46.

THIRD CAUSE FOR DISCIPLINE

(Falsified or Grossly Inconsistent Patient / Hospital Records)

48. Respondent is subject to disciplinary action under Code sections 2750, 2761, subdivision (a), and 2762, subdivision (e), in that Respondent made false, grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records, as more fully set forth above in paragraphs 11 through 47.

OTHER MATTERS

49. On or about December 11, 2003, Respondent was accepted into the Board's diversion program. On or about April 13, 2005, Respondent was terminated unsuccessfully from the diversion program for failure to comply with provisions of the rehabilitation plan.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 410602, issued to Leilani Sue Arney, aka Leilani Sue Aranda aka Leilani Sue Drake;

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2. Ordering Leilani Sue Arney to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/5/08

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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